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Medico-social and psychological model of rehabilitation of children with neurotic disorders who are in foster families under conditions of social stress

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Abstract

The article discloses the main original results of the study of children suffering from obsessive-compulsive disorder (OCD) in foster families in the territories of Ukraine liberated from the Russian occupiers. The substantiation of the medico-social and psychological model of rehabilitation of children with neurotic disorders who are in foster families under conditions of social stress caused by the war in Russia is given. For the first time, on the basis of the definition of the differential typology of the obsessive-compulsive symptom complex, a program of thorough treatment of patients with the mentioned disorders with different nosological affiliations was scientifically substantiated and developed as a combined system of psychopharmacotherapy and psychotherapy. It is the expansion of clinical ideas about the typology and registers of the obsessive-compulsive symptom complex as well as the expediency of taking them into account in therapy that made it possible to increase the effectiveness of treatment and rehabilitation measures for patients with this disorder. The comprehensive treatment program, which includes the first developed and implemented focal differentiated psychotherapy depending on the types of the obsessive-compulsive symptom complex, is specific and available for the use of psychiatric and psychotherapeutic help, social adaptation of this contingent in foster families, which is very important from the point of view of social policy and the development of its theory.

Keywords: obsessive compulsive disorder, schizotypal disorder with dominant obsessive-compulsive symptoms, typology diagnosis, complex treatment program

Introduction

Children from the territories liberated from the Russian invaders received and continue to get help from specialists in psychiatry, and psychotherapy along with the assistance that social services grant for foster families. However, in times of war, as the battle line approaches, systemic relationships in the dyad "Foster Family" – "State" undergo drastic changes. In particular, we have lost the ability to measure quantitatively the extent of reaching out to adopted children by state social services. The main goals of the said services are to protect children's life and health. According to the most recent information published by the Ministry of Social Policy, as of December 31, 2020, in Ukraine, there have been 1,235 orphanages run by families and 3,172 foster families. The general trend at that time was that the number of foster families decreased (by 174 families or by 5.5% compared to 2019) and the number of orphanages increased (by 82 families or by 6.6% compared to the same year)[2].

Various situations arise in conditions of social stress, and therefore, the level of response to them, manifestations of behavioural changes, will be different for each child.

[2] Ministry of Social Policy of Ukraine. The protection of children's rights is one of the priorities of the Ministry of Social Policy. Ministry of Social Policy. (2021). *Захист прав дітей є одним із пріоритетів Мінсоцполітики*. https://www.msp.gov.ua/news/20075.html?PrintVersion.

However, they all have one thing in common – anxiety. It is an axis around which all other elements line up: bad mood, decreased activity, and depersonalisation ("I have changed, I am not the same as others"). This applies especially to the cases when adopted kids compare themselves with peers who have natural parents, and to the cases of deactualisation ("The world has changed, it is not the same as it was before"). Therefore, in such cases, children need long-term therapy, sessions with a psychologist or psychotherapist, consultations with a psychiatrist, and social protection.

The comparative results of the study after the implementation of the complex treatment program allowed for determining the criteria of its effectiveness: a decrease in the level of anxiety and depression, an increase in the quality of life, and the use of more mature mechanisms, psychological protection and coping behaviour.

The traits of character and the proclivity for frustration in the child patient's personality play a significant role in adaptation to stressors. Psychotherapeutic correction, in turn, requires the development of an applied psychological model of rehabilitation at various levels. It makes it possible to reduce the maladaptive protective activity of the patient, promote the restoration of broken personal relationships, to improve awareness of one's capabilities in conflict resolution (Eterović et al., 2022; Tyrer et al., 2021a). For differentiated and adequate therapy of such patients, an analysis of the relationship between personal characteristics and neurotic disorders is necessary. It will significantly improve their mental state, reduce the clinical manifestations of the disease, as well as increase the effectiveness of the therapeutic effect of a biological nature and the possibility of developing an individual medical and social rehabilitation program (skills training, skills programming, resource coordination, resource modification) (Tyrer et al., 2021b; Maxwell et al., 2022; Krychun, 2013).

Thus, the problem of rehabilitation of patients with neurotic disorders comes to the front not only within the framework of psychiatry but also in general medicine (Krychun, 2014; Tsintsadze et al., 2015; Boltivets, 2016).

Considering all the above, we have completed an investigation of the patients with obsessive-compulsive disorder (OCD) in foster families. The factors that emphasise the social and clinical significance of new research on obsessive-compulsive symptoms (OCS) are the frequency of the disease, the severity of symptoms, frequent chronicity, and subsequent disability (Pyliahina et al., 2016; Krychun, 2016). The specificity of this disorder significantly worsens the social adaptation of patients: it makes it difficult to study and acquire social skills (Chelyadyn et al., 2016; Boltivets et al., 2017). The prevalence of the disorder justifies the need for optimal therapy, and the use of psychosocial means (Krychun, 2017; Boltivets et al., 2018).

For this purpose, we have carried out the theoretical justification and provided a practical solution to an important task in the field of psychiatry, namely, the formation of criteria for the development of an algorithm for treatment and rehabilitation measures. Also, we have created a toolkit for the differential diagnosis of OCD, namely of OCD and schizotypal disorder with dominant obsessive-compulsive symptoms (SCD with OCD) on the basis of detection and analysis of their clinical typology.

A total of 165 patients between the ages of 7–16 with OCD symptoms took part in the study under informed consent. These persons underwent inpatient treatment at the Territorial Medical Association (TMA) "Psychiatry" in Kyiv and outpatient

treatment at the Department of Psychiatry, Psychotherapy, and Medical Psychology of Shupyk National Healthcare University.

Using the criteria of ICD-10, we formed two groups. The first group, F42, included 96 patients (58.2%) diagnosed with OCD. The second group, F21, included 69 patients (41.8%) diagnosed with a schizotypal disorder with dominant obsessive-compulsive symptoms (SCD with dominant OCS).

In group F42 there were 17 children from foster families and family-type orphanages or 17.7% of the total number. In the F21 group, the number of children from foster families and family-type orphanages was 12 or 17.4% of the total number of children in this group. The main component of optimising treatment and rehabilitation, namely, the focus on four types of OCS, made it possible to eliminate these differences in family types. It also allowed the development of a differentiated program of complex treatment and the implementation of a procedural and algorithmic path for a patient with OCS.

The data obtained permitted also the development of an effective psychotherapeutic programme for the contingent understudy, which included the use of cognitive-behavioural therapy (CBT) and Gestalt therapy (GshT). The therapy consisted of 26 sessions, each lasting 60 minutes. The first and last sessions were exclusively diagnostic. Further work was performed with the obsessive-compulsive (OC) cycle, protection mechanisms, and family psychotherapy.

Thus, we developed and implemented a differentiated program of complex treatment and an algorithmic path for a patient with OCS. The analysis of the results of the medical and rehabilitation work made it possible to conclude that the use of such a therapeutic complex contributed to the reduction of OCD symptoms, the shortening of the duration of treatment and the increase of periods of remission, the improvement of the quality of life and social functioning.

Goal, object, subject and methods of the study

Based on the study of clinical and psychopathological features of OCD and typological variants of OCS, we developed differentiated PsT for the patients and optimised approaches to their psychosocial rehabilitation.

The object of research is obsessive-compulsive disorder, whereas **the subject of the study** is the clinical-psychopathological features and dynamics of the development of OCD, the quality of life and features of social support of patients in foster families, their treatment and rehabilitation.

Differentiated PsT for this contingent of patients on the basis of typological variants of OCD has been implemented in the practical work of the territorial medical association “PSYCHIATRIA” in Kyiv and the Regional Psychoneurological Hospital No. 3 in Ivano-Frankivsk, the Clinic of Occupational Diseases of the State University Kundiiev Institute of Occupational Medicine of the National Academy of Medical Sciences of Ukraine.

The results of the study of differential diagnosis and the use of PsT in patients with OCD are included in the programme of training cycles for psychiatrists,

psychotherapists and doctors – psychologists at the departments of psychiatry, psychotherapy and medical psychology of the P.L. Shupyk National University of Health Care of Ukraine, O.O. Bogomolets National Medical University, Kyiv, Department of Psychiatry, Narcology and Medical Psychology, Ivano-Frankivsk National Medical University and the State Institute of Family and Youth Policy of Ukraine.

The programme-targeted organisation of the research determined the staged and sequential nature of its implementation. The research design involved several stages: screening, formation of research groups with OCS and clinical-typological subgroups to evaluate the results of PsT application before and after treatment.

The study of the symptoms of OCD was carried out using the clinical scale of obsessions and compulsions (Yale-Brown Obsessive-Compulsive Scale and Symptom Checklist, Y-BOCS), which made it possible to assess the severity of the course of OCD; Hospital Anxiety and Depression Scale (HADS); quality of life assessment scales; the Multidimensional Scale of Perception of Social Support; the "Life Style Index" questionnaire (LSI), the "Psychological diagnosis of the strategy of coping behaviour" method.

Statistical data processing was carried out using the program SPSS 16.0 and Microsoft Exel from the package Microsoft Office 2003.

Methods of the study included clinical-anamnestic, socio-demographic, clinical-psychopathological, psychodiagnostic, catamnestic, and statistical.

Research results

During the study of the clinical and psychopathological traits of the OCS in the groups, we discovered the following. Estimating the OCS severity indicators (with the clinical Y-BOCS scale) in the groups, we have seen that the severity of the course of OCD in the F42 group was moderate, whereas in the F21 group, prevailed both moderate and severe degrees.

Clinical level of anxiety and depression (according to the HADS scale) was statistically significantly more common in the F42 group than in the F21 group ($p=0.001$). On the other hand, the patients of the F21 group more frequently showed a subclinical level of depression than those of the F42 group (20.1%, $p=0.004$). A lower level of anxiety and depression in F42 patients is explained by reduced criticism of their condition.

The pathopsychological study of patients proved that the difference in the formation of OCS in groups F42 and F21 had a psychological foundation. So according to the Quality of Life Estimation scale, 55.1% of the patients in the F21 group estimated their quality of life as average, while 60.4% of the F42 ones estimated it as low ($p=0.001$).

Also, we obtained the survey data according to the MSPSS various scale: 68.8% of patients in the F42 group felt support from family and in 27.1% of cases – support from friends, on the other hand, 49.3% of patients in the F21 group found support only in the family circle.

The testing of patients according to the LSI scale proved that within different registers of psychopathological disorders, completely different mechanisms of psychological

protection are realised. Namely, the patients of the F42 group showed more mature variants of the protective structure ($p<0.05$): reactive formation (68.8%), rationalisation (59.4%) and repression (75%). At the same time, other styles of protective mechanisms were characteristic for the patients of group F21 ($p<0.05$): regression (58%), substitution (62.3%), repression (60.9%), and reactive formation (37.7%). Defence mechanisms such as displacement and reactive formation were common for both groups.

As for the testing with the Coping Behavior Diagnostics (CBD) scale, in the F42 group prevailed coping strategies aimed at reducing emotional discomfort ($p<0.05$): distancing (54.2%), self-control (67.7%), and seeking social support (44.8%). At the same time, the F21 group was dominated by self-control (73.9%) and escape avoidance (55.1%).

The main goal of our study was to determine the clinical typology of the OCS (Table 1).

Principal components analysis and multidimensional regressions made it possible to discover and describe relations between particular clinical parameters specific to each type of OCS. According to the results obtained with the Y-BOCS scale and their evaluations for each patient, 14 main factors were selected from the whole list of symptoms. The Quartimax procedure was the methodological basis of the conducted analysis. It assesses the importance of individual symptoms in the formation of factor loadings. With it, we were able to distribute factors by the sets of specific symptoms correlating strongly for each of the selected four components (a set of certain factors). These could be interpreted as separate types of OCS.

As we studied two groups of patients: with OCD and with SCD with OCS, we conducted a similar factor analysis within each group to determine the specificity of the distribution of factors (components) and the weight of individual symptoms in each group.

For the patients within the OCD group F42, the first three components were significant, i.e., the following types of OCD: T-incompleteness, T-avoidance, and T-ambivalence. For T-incompleteness, symptoms of symmetry and order compulsion ($r=0.895$), rituals of repetition ($r=0.637$), and obsession with symmetry and order ($r=0.526$) had the greatest weight. T-avoidance showed the most significant relationship with the following symptoms (in rank order): compulsive checking ($r=0.802$), obsessions with pollution ($r=0.781$), obsessions with religious content ($r=0.646$), obsessions with hypochondriac content ($r=0.589$) and cleaning compulsions ($r=0.511$). T-ambivalence was characterised by a strong correlation with the presence of sexual content obsessions ($r=0.814$), dysmorphophobic content obsessions ($r=0.813$), and aggressive thoughts ($r=0.686$). The symptom of compulsive neurotic excoriations is somewhat less significant for this group; however, it also has some significance ($r=0.532$). An important result was that for patients of the F42 group, the correlation of symptoms with component 4, namely, with T-accumulation, was completely uncharacteristic. Thus, it was proved that this type is not inherent in OCD patients.

The purpose of the diagnostic stage was to determine the type of OCS and their traits in various nosologies. An important component of the diagnostic stage was the determination of a differentiated psychotherapeutic prescription for the patients. It was found that depending on the register of psychopathological disorders

Table 1. Factor loadings quartimax-rotation of data from the Y-BOCS scale to determine components of OCS in patients

Symptoms	Factor loadings/types of OCS n=165			
	Component 1 (T-incompleteness)	Component 2 (T-evasion)	Component 3 (T-ambivalence)	Component 4 (T-accumulation)
Obsessions of symmetry and order	**0.643**	0.327	0.186	0.320
Obsessions of contamination	0.148	**0.732**	0.050	-0.203
Aggressive thoughts	0.022	0.268	**0.757**	0.034
Obsessions of hypochondriacal content	-0.379	**0.535**	0.016	0.257
Obsessions of sexual content	0.190	0.076	**0.706**	-0.210
Obsessions of religious content	-0.053	**0.653**	0.130	-0.378
Obsessions of dysmorphic content	-0.013	0.048	**0.786**	-0.068
Other obsessions	0.044	-0.012	0.085	**0.814**
Compulsions of symmetry and order	**0.793**	0.202	0.078	-0.034
Rituals of repetition	**0.748**	0.353	0.108	0.131
Compulsions of purification	0.264	**0.581**	-0.347	-0.335
Compulsive checks	0.192	**0.761**	-0.008	0.205
Compulsive neurotic excoriation	0,080	-0.006	**0.640**	0.090
Collecting and gathering compulsions	0,099	0.210	-0.137	**0.792**

and types of OCS there is a significant difference in the focal targets of psychoterapy (PsT). PsT in both groups was carried out for six months – 28 one-hour sessions once a week. The first and last sessions were exclusively diagnostic, and 24 sessions were therapeutic. The second session was devoted to the construction of a graphic image of the OK-cycle to determine the anomaly of its structure. In the minds of patients, the OK-cycle is the single continuum with which the individual copes with intrusive, Ego-dystonic (in patients of group F42) and Ego-syntonic (in patients of group F21) thoughts. The visualisation enabled patients, with the help of the doctor's explanatory information, to activate constructive self-configuration of thoughts and feelings, self-optimisation of actions, and self-restoration of the mental state.

The manifestations of the OCS that were reproduced in the graphical image of the OC cycle made it possible to determine the points or focal targets

of the psychotherapeutic intervention in the PsT. The point is a conventional zone where it is determined which type of therapy is the most effective – psychopharmacotherapy (PfT) and/or PsT (CBT and/or GshT). So, when it was an OCS related to point one (dominance of the compulsions against a high level of anxiety), it made sense to apply a psychotherapeutic intervention along with the CBT technics; in the case of point two (dominance of obsessive thoughts that directly led to significant anxiety alleviation) it was immediately necessary to prescribe the PfT; with point three (influence of exterior stimuli leading to obsessive thoughts) – the most effective way was to utilise the psychotherapeutic techniques of GshT.

As a result of the diagnosis, it was found that in group F42, in patients with T-incompleteness, the main manifestations of OCS were related to points one and three, which made it possible to conduct their therapy in the form of PsT, as monotherapy (MonoT). Whereas in patients with T-avoidance and T-ambivalence, the manifestations that dominated first were related to points one, three (designation of PsT), and then to point two. It was the main reason to prescribe combined therapy (CombT, a combination of PsT and PfT).

In F21 quite different types of OC cycle anomalies showed up. That implied implementation of another variant of PsT. Namely, in patients with T-avoidance and T-ambivalence initially dominated the symptoms associated with point two, and this required the initial prescription of PfT; then the transition to PsT took place when the manifestations of OCS associated with points I and III began to dominate. And only in patients with T-accumulation, the main focus of treatment was symptoms characteristic of point two, which made it reasonable to prescribe MonoT in the form of PfT to these patients.

Discussion

It was established that the diagnostic stage of the study made it possible to develop a differentiated PsT taking into account the clinical typology of OCS, its nosological affiliation and the register of psychopathological disorders.

The clinical stage of PsT was directly aimed at reducing the manifestations of OCS with a combination of PsT and PfT (CombT) or their utilisation in the form of MonoT. And it was the complex approach to treatment that ensured its effectiveness, which was proven in a repeated (after six months) and catamnestic (after two years in the F21 group) study.

Psychotherapy became the most valuable part of PsT in all types of OCS. And regardless of the OCS type and the register of psychopathological disorders, it turned out that it was appropriate to start PsT with the regulation of the external cycle, which means breaking the influence of anxiety on the onset of compulsions. We demonstrated that for the patients with all types of OCS in the F42 group (T-incompleteness, T-avoidance and T-ambivalence) and the patients with T-avoidance and T-ambivalence in the F21 group in the case of external cycle symptoms domination psychotherapeutic intervention lasting from three to six sessions was of primary importance. The further PsT was concerned with the symptoms of the internal OC cycle, i.e., with the resolution

of the subconscious transition of whatever external stimuli into obsessive thoughts through the exposure of reactions (needs). Such intervention, as an engagement with the personality, should be lasting because OCD is an external manifestation of the patient's subconscious internal conflict. In the formation of OCD or of SCD with OCS, unconscious needs block any manifestation of emotional experiences and are subject to personal control, and intellectualisation. Namely, this point served as the basis for a working psychotherapeutic hypothesis for persons with PsT.

For patients from the F42 group, the statistically significant focal point of PsT was the identification of defence mechanisms. Task common for all types in the group was dealing with ($p<0.05$) repression, regression, reactive formation, and rationalisation; for patients with T-incompleteness, it was also dealing with compensation; for patients with T-ambivalence, it was working with displacement. In the F21 group, we proved reliably that the focus of differentiated PsT for patients with T-avoidance and T-ambivalence was the development of the following defence mechanisms ($p<0.05$): displacement, regression, substitution, and reactive formation.

In the F21 group, we proved reliably that the focus of differentiated PsT for patients with T-avoidance and T-ambivalence was the development of the following defence mechanisms ($p<0.05$): repression, regression, displacement, and reactive formation. As for the persons with T-accumulation, we considered only the displacement mechanism.

Coping strategies, discovered in both groups with the help of the CBS scale, were also the focus of six months of personal therapy.

In the course of the study and implementation of the differentiated PsT, we have optimised PfT for patients with OCS. For patients of the F42 group, we prescribed medium-therapeutic and maximum doses of antidepressants (AD), and only when dealing with resistant forms of the disease – small doses of atypical antipsychotics (AP) and thymoleptics (TML). On the other hand, to reduce OCS in the group F21 patients, the prescription of atypical AP with the addition of medium-therapeutic doses of AD was mandatory.

After six months of PsT, we analysed the dynamics of the indicators obtained with the scales that we used during diagnostic studies. The analysis showed reliably that after the PsT in group F42, the severity of the OCD greatly reduced. In patients with T-incompleteness, T-avoidance, and T-ambivalence, the number of cases with moderate and mild OCD significantly decreased ($p<0.05$). It turned out to be characteristic for patients with T-incompleteness and T-avoidance that the manifestations of a severe course disappeared and the number of cases of absence of OCD symptoms increased ($p<0.05$).

It turned out to be characteristic for patients with T-incompleteness and T-avoidance that the manifestations of a severe disease course disappeared and the number of cases without OCD symptoms increased ($p<0.05$).

In patients in the F21, both with T-avoidance and T-ambivalence, the criterion for the effectiveness of PsT was a significant decrease in the extremely severe course of OCS and an increase in the mild course ($p<0.05$). Indicators of the severity of the disorder course in persons with T-accumulation did not change significantly. A positive criterion in the treatment was a decrease in the rate of severe OCS by 16.7%.

As a result of the PsT, the coping strategies in both groups of patients acquired different characteristics and expressions. Thus, in the F42 group, they transformed into the behaviour of confrontation, acceptance of responsibility, and positive reevaluation of thoughts and own behaviour ($p<0.05$). Namely, for patients with T-incompleteness and T-avoidance, there was a common decrease in the indicators of ($p<0.05$) distancing, self-control, seeking social support, and escape avoidance. It was characteristic that the patients with T-incompleteness showed a decrease in the planning of problem resolution ($p<0.05$) and the ones with T-ambivalence – a drop in self-control ($p<0.05$). In the F21 group, coping strategies changed to acceptance of responsibility ($p<0.05$). In patients of this group with T-avoidance and T-ambivalence, the indicators of self-control decreased ($p<0.05$).

Patients with T-accumulation in the F21 group did not have PsT in contrast to other patients in the two groups for whom the clinical stage of the PsT included PsT. Therefore, in this group after two years we performed an analysis of the reduction of OCS, namely, comparing the F21 patients who received PsT and those who did not. A catamnestic study included 52 patients who had SCD with OCS. According to what the Y-BOCS scale said, those with T-avoidance and T-ambivalence who were under CombT showed insignificant fluctuations in the severity of OCD. On the other hand, the patients with T-accumulation exclusively on MonoT in the form of PfT, showed statistically significant changes in the severity indicators. Namely, the number of patients with moderate OCD decreased significantly by 42.9% ($p=0.018$); at the same time, the number of those with a severe disorder increased by 42.8% ($p=0.018$).

The rehabilitation stage was aimed at restoring or maintaining the optimal level of psychological, social, and labour adaptation, identifying and activating intrapersonal resources, increasing periods of remission, and preventing the recurrence of OCS episodes.

As a result of the study and implementation of PsT for persons with OCD and SCD with OCS, we developed and presented a summary algorithm of how to define the path for the patients with OCS which is consistent with the applied differentiated formulation of diagnosis and PsT. This algorithm (please see Table 2) provides the possibility for health care specialists, namely, psychiatrists and psychotherapists, to diagnose types of OCD, take a differentiated approach to prescribing PfT and conducting PsT, as well as to apply effective rehabilitation measures for patients with OCD and patients with SCD with OCS.

Conclusions

In the conditions of war and martial law, the dynamics of the development of traumatic changes in children's mental states are unpredictable, but according to our data, about a third of all injuries are psychiatric pathologies. That is, absolutely healthy children at the time of military operations and forced migration, begin to have pronounced mental disorders to a certain extent, and exacerbation of mental symptoms in those who previously suffered from mental pathologies.

In the study, we determined the difference in the perception of the quality of life in patients with OCD (according to the Quality of Life Scale, QLS): patients in the F42 group in 60.4% of cases rated it as low, while 55.1% of the patients in the F21 group characterised it as being at an average level ($p<0$ .05). This shows the peculiarities of the subjective perception of the disease and the decrease in its criticism in the patients of the latter group.

The results obtained with the MSPSS scale showed that 68.8% of patients in the F42 group felt support from family and in 27.1% of cases – support from friends, while 49.3% of patients in the F21 group found support only in the family circle.

According to the ILS scale, we revealed that in the F42 group characteristics were more mature variants of the protective structure: reactive formation, rationalisation, and compensation ($p<0.05$). In the F21 group, regression, displacement, and denial were characteristic ($p<0.05$). Common for both groups was a replacement as a protection mechanism.

The CBS scale data showed that the F42 was dominated by coping strategies of distancing, self-control, and acceptance of responsibility whose goal was mainly to decrease emotional discomfort. In the F42 group, coping strategies of self-control and escape avoidance prevailed. These strategies also served as a focus for PsT. Further, they acted as a focus for the personal PsT.

The study of clinical manifestations in the patients (with the Y-BOCS scale), made it possible to prove the determination of four clinical types of OCS: incompleteness, avoidance, ambivalence, and accumulation. For the patients with OCD (F42 group), T-incompleteness, T-avoidance and T-ambivalence turned out to be specific types. For the patients with SCD with OCS (F21 group), T-avoidance and T-accumulation were specific.

In the course of the research, a differentiated PsT was developed considering the clinical and psychopathological features and clinical typology of OCD as well as the register of psychopathological disorders. It has three stages: diagnosis, therapy, and rehabilitation. The goal of the diagnostic stage is to determine the type of OCS, according to its nosological affiliation. Also, at this stage, the focus targets of the PsT are determined using a graphical image of the OC cycle. The clinical stage tries to reduce the manifestations of the OCS with the help of the CombT (combination of PsT and PfT) or the MonoT (PsT or PfT).

The rehabilitation stage of PsT aims to restore or maintain the optimal level of the patient's psychological and social adaptation, increasing periods of remission and preventing the recurrence of OCS episodes with the help of psychotherapeutic (CBT and GshT) and psychoeducational measures. These measures should be carried out with patients with all types of OCS, regardless of nosological affiliation and register of psychopathological disorders.

The use of PsT made it possible to optimise PfT for patients with OCS. Namely, we prescribed AD to the F42 group patients in medium therapeutic and maximum doses and only dispatched small doses of atypical AP and TmL to those who had resistant forms of the disease. At the same time, to reduce OCS in patients in the F21 group, the prescription of atypical AP with the addition of medium therapeutic AD was mandatory.

The study made it possible to scientifically substantiate and develop a system of focal differentiated PsT depending on the types of OCS, their nosological affiliation, and defined focus targets of therapeutic intervention using a graphic image of the OC cycle. Namely, when the realisation of compulsions dominated against the background of a high level of anxiety, it was appropriate to use psychotherapeutic intervention with the help of CBT techniques. Under the influence of external stimuli that potentiated obsessive thoughts, the use of GshT was effective. However, in the case when obsessive thoughts dominated, directly causing a significant rise in the anxiety level, the priority was to prescribe the PfT and then CombT (a combination of PsT and PfT).

A statistically reliable focus of PsT was work with identified defence mechanisms: for patients from the F42 group – replacement, regression, compensation, displacement, reactive formation, and rationalisation ($p<0.05$), in the F21 group – replacement, regression, displacement and reactive formation ($p<0.05$). We have not observed any significant difference in the indicators in the results of treatment and rehabilitation of children from native and foster families and family-type orphanages.

The study demonstrated a possibility of the successful overcoming of OCS with PsT (MonoT, CombT). The program allows for influencing effectively all components of a patient's mental state and social functioning under all types of OCS. The comparative results of a repeated study (after the implementation of PsT) made it possible to determine the criteria of its effectiveness: reduction of levels of anxiety and depression, improvement of quality of life, application of more mature mechanisms of psychological protection and coping behaviours.

References

Boltivets, S., Gonchar, T., Uralova, L., Gonchar, O., & Chelyadyn, Y. (2016). Geopsychology of central European nations harbingers of grief in the states of illusions methodology of geopsychological securitas. In A. Kwiatkowski (Red.), *Europa w dobie kryzysu migracyjnego* (191–199). Wyższa Szkoła Bezpieczeństwa Publicznego i Indywidualnego „Apeiron".

Boltivets, S.I., Gonchar, O.A., Gonchar, T.O., Uralova, L.T., & Chelyadyn, Y.Y. (2017). Psychotherapeutic correction of deviant behavior caused by mental disorders in children and young adults. *Znanstvena misel*, *2*, 16-19.

Boltivets, S., Chelyadyn, Y., Gonchar, T., Uralova, L., & Gonchar, O. (2018). Psychotherapy of patients with hypochondriac and obsessive-compulsive disorders due to perinatal cerebrovascular lesions. *Problems of Psychology in the 21st Century*, *12*(1), 8-16.

Boltivets, S., Chelyadyn, Y., Gonchar, T., Uralova, L., & Gonchar, O. (2022). Obsessive-Compulsive Disorders of waiting for Death as a Result of Military Genocide of the Ukrainian Population. *Mental Health & Human Resilience International Journal*, *6*(1), 000173. https://medwinpublishers.com/MHRIJ/obsessive-compulsive-disorders-of-waiting-for-death-as-a-result-of-military-genocide-of-the-ukrainian-population.pdf

Chelyadyn, Y., Gonchar, T., & Uralova, L. (2016). Social and mental rehabilitation of the patients with the obsessivecompulsive disorder and hypochondriasis. *Problems of Psychology in the 21st Century, 10*(2), 77-84.

Eterović, M., Lucanić, D., Kranjčević, M., Marinić, I., & Marinić, LM. (2022). Coping in Extreme Conditions. *The Journal of Nervous and Mental Disease, 210*(2), 104-110.

Krychun, Y. (2013). Medico-social and psychological model of rehabilitation of patients with obsessive-compulsive disorder. *Mental Health*, *4*(41), 25-31.

Krychun, Y. (2014). Modern pathogenetic approaches to the treatment of obsessive-compulsive disorder. *Mental Health, 4*(45), 39-45.

Krychun, Y. (2016). Assessment of the relationship between the severity of obsessive-compulsive disorder and indicators of orderly behavior in stressful and problematic situations for the individual in terms of medical and social rehabilitation. Collection of scientific works of the staff of the National Medical Academy of Postgraduate Education named after Platon Shupyk. *25*, 417-422.

Krychun, Y. (2017). Understanding the phenomenology of obsessive-compulsive disorder from the standpoint of Gestalt therapy. *Mental Health*, *4*(53), 50-54.

Maxwell, C.J., Maclagan, L.C., Harris, D.A., Wang, X., Guan, J., et al. (2022), Incidence of neurological and psychiatric comorbidity over time: a population-based cohort study in Ontario, Canada. *Age Ageing*, *51*(2): afab277. doi: 10.1093/ageing/afab277

Pyliahina, H., Kuznetsov, V.M., Honchar, T.O., & Cheliadyn, Y. (2016). Therapy of psychological protection and orderly behavior in obsessive-compulsive disorder. *Information letter on innovations in the field of health care*, *15*(281).

Tsintsadze, N., Beridze, L., Tsintsadze, N., Tsivadze, N., Tsintsadze, M., et al. (2015). Psychosomatic aspects in patients with dermatologic diseases. *Georgian Medical News, 6*(243), 70-75.

Tyrer, P., Tyrer, H., & Yang, M. (2021a). Premature mortality of people with personality disorder in the Nottingham Study of Neurotic Disorder. *Personality and Mental Health, 15*(1), 32-39.

Tyrer, P., Tyrer, H., Johnson, T., & Yang, M. (2021b). Thirty-year outcome of anxiety and depressive disorders and personality status: Comprehensive evaluation of mixed symptoms and the general neurotic syndrome in the follow-up of a randomised controlled trial. *Psychological Medicine*, *2021*, 1-10. doi: 10.1017/S0033291721000878

List of abbreviations

OCD – obsessive-compulsive disorder
OCS – obsessive-compulsive symptom complex
SCD with OCS – schizotypal disorder with dominant obsessive-compulsive symptoms
CTP – complex treatment program
PfT – psychopharmacotherapy
Y-BOCS –Yale-Brown Obsessive-compulsive Scale and Symptom Checklist
HADS – Hospital Anxiety and Depression Scale

QLS – Quality of Life Scale
MSPSS – The Multidimensional Scale of Perceived Social Support
LSI – Life Style Index
CBD – Coping Behavior Diagnostics
MonoT – monotherapy
CombT – combined therapy
PfT – psychopharmacotherapy
AD – antidepressants
AP – atypical antipsychotics
TmL – thymoleptics
PsT – psychotherapy
CBT – cognitive behavioral therapy
GshT – Geschtalt therapy
OC cycle – obsessive-compulsive cycle